

Appendix 2. Investigation of GAS outbreak in an Long Term Care Facility, 2016 Resident Record Extraction Form

Form Approved; OMB No. 0920-1011
Exp. Date 03/31/2017

Person completing form _____

Date Completed: ___/___/___

Resident (check one): Case Control

If CONTROL, date of matched case's GAS culture: ___/___/___

A. GAS TESTING RESULTS

1. Did resident have any cultures/tests positive for GAS?

Yes No

#	Date obtained	Site cultured
a.	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Pleural <input type="checkbox"/> Skin/Wound: _____ <input type="checkbox"/> Rapid strep <input type="checkbox"/> Sputum <input type="checkbox"/> Joint <input type="checkbox"/> Other _____ <input type="checkbox"/> Throat <input type="checkbox"/> Central line/TPN <input type="checkbox"/> Catheter
b.	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Pleural <input type="checkbox"/> Skin/Wound: _____ <input type="checkbox"/> Rapid strep <input type="checkbox"/> Sputum <input type="checkbox"/> Joint <input type="checkbox"/> Other _____ <input type="checkbox"/> Throat <input type="checkbox"/> Central line/TPN <input type="checkbox"/> Catheter
c.	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Pleural <input type="checkbox"/> Skin/Wound: _____ <input type="checkbox"/> Rapid strep <input type="checkbox"/> Sputum <input type="checkbox"/> Joint <input type="checkbox"/> Other _____ <input type="checkbox"/> Throat <input type="checkbox"/> Central line/TPN <input type="checkbox"/> Catheter
d.	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Pleural <input type="checkbox"/> Skin/Wound: _____ <input type="checkbox"/> Rapid strep <input type="checkbox"/> Sputum <input type="checkbox"/> Joint <input type="checkbox"/> Other _____ <input type="checkbox"/> Throat <input type="checkbox"/> Central line/TPN <input type="checkbox"/> Catheter
e.	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Pleural <input type="checkbox"/> Skin/Wound: _____ <input type="checkbox"/> Rapid strep <input type="checkbox"/> Sputum <input type="checkbox"/> Joint <input type="checkbox"/> Other _____ <input type="checkbox"/> Throat <input type="checkbox"/> Central line/TPN <input type="checkbox"/> Catheter
f.	___/___/___	<input type="checkbox"/> Blood <input type="checkbox"/> Pleural <input type="checkbox"/> Skin/Wound: _____ <input type="checkbox"/> Rapid strep <input type="checkbox"/> Sputum <input type="checkbox"/> Joint <input type="checkbox"/> Other _____ <input type="checkbox"/> Throat <input type="checkbox"/> Central line/TPN <input type="checkbox"/> Catheter

B. RESIDENT BACKGROUND

2. Sex: Male Female

3. Age: _____

4. Date of birth: ___/___/___

5a. Room history for 1 month prior to GAS culture (for case) or time of time match (for control):

Room # (floor/wing)	Dates in room	Type of room	Roommate (dates)
a.	___/___/___ to ___/___/___	<input type="checkbox"/> Private <input type="checkbox"/> Double <input type="checkbox"/> Triple	___/___/___ to ___/___/___
b.	___/___/___ to ___/___/___	<input type="checkbox"/> Private <input type="checkbox"/> Double <input type="checkbox"/> Triple	___/___/___ to ___/___/___
c.	___/___/___ to ___/___/___	<input type="checkbox"/> Private <input type="checkbox"/> Double <input type="checkbox"/> Triple	___/___/___ to ___/___/___
d.	___/___/___ to ___/___/___	<input type="checkbox"/> Private <input type="checkbox"/> Double <input type="checkbox"/> Triple	___/___/___ to ___/___/___

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Public reporting burden of this collection of information is estimated to average 45 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

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e.	___/___/___ to ___/___/___	<input type="checkbox"/> Private <input type="checkbox"/> Double <input type="checkbox"/> Triple	___/___/___ to ___/___/___
f.	___/___/___ to ___/___/___	<input type="checkbox"/> Private <input type="checkbox"/> Double <input type="checkbox"/> Triple	___/___/___ to ___/___/___

5b. Did the resident have a roommate with GAS infection or colonization?

Yes No Unknown *If yes: initials of GAS+ roommate* ___ *Dates room shared:* _____

5c. Did the resident have frequent visitors during his stay in the facility? (if no, skip to 6)

Yes No Unknown

If yes: how many days per week? _____ *How many regular visitors/week?* _____

6. Total length of stay at facility (most recent stay only) at time of GAS culture (*mark only one*):

≤ 1 week 1-3 weeks 4-8 weeks ≥ 8 weeks

7a. Is the resident deceased? Yes No *If yes, date of death:* ___/___/___

b. If resident died, death was: Related to GAS infection Possibly related to GAS infection
 Not related Not applicable

8. Resident's physicians?

Physician's name	Name of practice	Specialty (e.g., wound care, etc.)
a.		
b.		
c.		
d.		

9. List last admission prior to GAS infection or time of match for controls (including home, facility, hospitals, and any other LTCF).

Name & location	Admission date	Discharge date	Diagnosis (if applicable)	Admission from:
a.	___/___/___	___/___/___		
b.	___/___/___	___/___/___		

C. MEDICAL HISTORY

10. Which medical condition(s) does the resident have? (*mark ALL that apply*):

- Diabetes CHF/history of MI Peripheral vascular disease Stroke
 Asthma/COPD Hypertension Chronic leg edema Recent herpes zoster
 Dialysis Renal insufficiency Dementia Chronic skin condition
 Cancer, specify type: _____ Immunosuppressed/immunosuppression None

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Cirrhosis Recent IV Drug Use Prosthetic Other: _____

(Note: immunosuppression includes: HIV/AIDS, chemo, radiation, immunosuppressive meds, including tacrolimus [Prograf], sirolimus [Rapamune], mycophenolate mofetil [Cellcept], high-dose or chronic steroids [prednisone, methylprednisone, hydrocortisone, dexamethasone] methotrexate.)

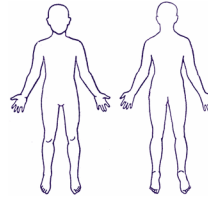
11. Weight: _____ lbs or kg (*circle unit of measure*) 12b. Height: _____

12. Did patient have any surgical wounds, pressure ulcers, or other wounds at the time of admission to the facility?
 Yes If yes, how many _____ No

13. Did patient have any surgical wounds, pressure ulcers, or other wounds at the time of first GAS isolation for case or at time-match for controls?

No Yes If yes, how many _____

Indicate location(s):



14. Did the patient receive wound care consultation services within 1 month prior to the GAS case or time-match for controls?

Yes No

Dates	Name(s) of doctors or nurses

15. Did the patient receive wound care WITHOUT wound care consultation within 1 month prior to GAS case or time-match for controls?

Yes No

16. Products used for wound care (surgical and nonsurgical) (*check all*):

Versafoam Granufoam Prisma Wound Matrix Mepilex Accuzyme

Ethyzyme DuoDerm Biotane Foam Hydrogel Wound vac

Antimicrobial cleanser/cream None Other: _____

17. Has the patient had a surgical procedure within 1 month of GAS infection or time match for control?

Yes No

Procedure	Date	Incision Site

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	____ / ____ / ____	
	____ / ____ / ____	

18. Type of IV access present at time of positive GAS culture/referral from CC? None Not applicable

15a. Access Type	15b. Date of Insertion	15c. Person Inserting (e.g. RN)

19. At time of GAS culture (case) or time-match (for control), was the resident diagnosed with:

- | | | | |
|--------------------|------------------------------|-----------------------------|----------------------------------|
| a. Cellulitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date of onset ____ / ____ / ____ |
| b. Wound infection | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date of onset ____ / ____ / ____ |
| c. Pharyngitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date of onset ____ / ____ / ____ |
| d. Bacteremia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date of onset ____ / ____ / ____ |
| e. Pneumonia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date of onset ____ / ____ / ____ |
| f. Joint Infection | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date of onset ____ / ____ / ____ |

20. Within 1 month of GAS culture or time-match for control, did the resident have any of the following signs or symptoms? (mark ALL that apply)

		Date of onset (dd/mm/yy)	
a.	<input type="checkbox"/> Fever ($\geq 100.5^\circ\text{F}$ or 38°C)	____ / ____ / ____	Max temp recorded:
b.	<input type="checkbox"/> Sore throat	____ / ____ / ____	
d.	<input type="checkbox"/> Purulent discharge from wound	____ / ____ / ____	Site:
e.	<input type="checkbox"/> Wound – warm on touch	____ / ____ / ____	Site:
f.	<input type="checkbox"/> Wound – redness	____ / ____ / ____	Site:
g.	<input type="checkbox"/> Edema at the site	____ / ____ / ____	Site:
h.	<input type="checkbox"/> Increased pain at the site	____ / ____ / ____	Site:
i.	<input type="checkbox"/> Joint – warm on touch	____ / ____ / ____	Site:
j.	<input type="checkbox"/> Joint – redness	____ / ____ / ____	Site:
k.	<input type="checkbox"/> Joint – warm on touch	____ / ____ / ____	Site:

C. RESIDENT BASELINE STATUS (Can get further information from nursing)

21. Which appliances does the resident use (mark ALL that apply):

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Tracheostomy | <input type="checkbox"/> Nasal cannula | <input type="checkbox"/> Oxygen mask | <input type="checkbox"/> Chronic Foley |
| <input type="checkbox"/> G or J tube | <input type="checkbox"/> Nasogastric tube | <input type="checkbox"/> Colostomy/ileostomy | <input type="checkbox"/> Temporary Foley |
| <input type="checkbox"/> Dialysis catheter | <input type="checkbox"/> PICC line | <input type="checkbox"/> Other, specify: _____ | |

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22. Describe the resident's ambulatory status: (mark ALL that apply)

Walks independently Walks with support Wheelchair Geri chair Bed bound

23. Indicate if resident incontinent of: (mark ALL that apply)

Stool Urine Not Incontinent Urinary catheter Colostomy/Ileostomy Unknown

24. Is the resident being tube fed? Yes No

25. Did the resident participate in the following activities in the 1 month prior to diagnosis or time-match for controls (mark ALL that apply):

a.	<input type="checkbox"/> PT/OT	Times per 2 month period: _____
b.	<input type="checkbox"/> Speech pathology	Times per 2 month period: _____
c.	<input type="checkbox"/> Podiatry	Times per 2 month period: _____
d.	<input type="checkbox"/> Other: _____	Times per 2 month period: _____